Physical Therapy

Which providers are eligible to provide physical therapy?
[Refer to WAC 388-545-500(1)]

- Licensed physical therapists or physiatrists; or
- Physical therapist assistants supervised by licensed physical therapists.

Where must physical therapy services be provided?
[WAC 388-545-500(3)(a)(f)]

HRSA pays eligible providers for physical therapy services provided as part of an outpatient treatment program in the following settings:

- In an office, home, or outpatient hospital setting;

> **Note**: Physical therapy may be performed by a home health agency as described in Chapter 388-551 WAC, or as part of an acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC.

- In a neurodevelopmental center;

- In a school district or educational service district facility as part of an individual education plan (IEP) or individualized family service plan (IFSP), as described in WAC 388-537-0100; or

- For children two years of age and younger with disabilities, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

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Referral and Documentation Process

Adults (Age 21 and older) **[Refer to WAC 388-545-500 (5)]**

Providers must document in a client's medical record that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's medical record.

The provider must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the referred child.

Coverage [WAC 388-545-500(4)]

HRSA pays providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

> **Note**: HRSA does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) **[Refer to WAC 388-545-500 (8)]**

HRSA covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- One visit to instruct the client in the application of transcutaneous electrical neurostimulator (TENS) per lifetime.
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment;
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

HRSA covers up to 96 physical therapy program units per calendar year *in addition* to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.31-315.9, 317-319	Medically necessary conditions for individuals identified as having developmental disabilities
343.0 - 343.9	Cerebral palsy
741.90-741.93	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800.00 - 829.1	Surgeries involving extremities – Fractures
851.00 - 854.19	Intracranial injuries
880.00 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941.00 - 949.5	Burns
950.0 - 957.9, 959.01 - 959.9	Traumatic injuries

Note: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy following an approved Acute PM&R stay within the previous 12 months for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854.00-854.19	Traumatic brain injury
900.82, 344.00- 344.09, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343.0 – 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)

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ICD-9-CM Diagnosis Codes	Condition
941.40-941.49, 941.50-941.59, 942.40-942.49, 942.50-942.59, 943.40-943.49, 943.50-943.59, 944.40-944.48, 944.50-944.58, 945.40-945.49, 945.50-945.59, 946.4, 946.5	Extensive severe burns
344.00-344.09, 707.00-707.09	Skin flaps for sacral decubitus for quads only
890.0 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

HRSA does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

> **Note**: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97761).

- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). HRSA covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.
- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.
- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97760). HRSA covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.
- Active wound care management involving selective and non-selective debridement (CPT codes 97597, 97598, and 97602). The following conditions apply:
  - ✓ HRSA covers one unit of CPT code 97597, 97598, and 97602 per client, per day, per wound. Providers may not bill CPT codes 97597, 97598, and 97602 in conjunction with each other for the same wound; however, CPT codes 97597, 97598, and 97602 may be billed in conjunction with each if they are for separate wounds.
  - ✓ Providers must not bill CPT codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

Note: For multiple wounds, use modifier 59.

- Checkout for orthotic/prosthetic use (CPT code 97762). HRSA covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Wheelchair management (CPT code 97542).

- Wheelchair needs assessment (CPT code 97542). HRSA covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97762). HRSA covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.

- Splints (refer to Section K for those splints covered in a provider's office).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

HRSA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to HRSA's *School Medical Services Billing Instructions*. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

HRSA does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to HRSA-contracted facilities.

DDD Physical: HRSA covers one physical every 12 months for clients with disabilities. Use HCPCS code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

HIV/AIDS Counseling: HRSA covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS counseling per client, per lifetime. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling.

Needle Electromyography (EMGs): HRSA has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas two extremities… three extremities… four extremities…	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95865	Muscle test, larynx	• Limited to one unit per day.
95866	Muscle test, hemidiaphragm	• Limited to one unit per day.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

TB Treatment Services: The E&M codes 99201-99215 are for office visits only, and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

When billing for TB treatment services provided by professional providers in the client's home, Health Departments may also bill CPT codes 99341 and 99347.

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier).

Note: Continue to bill using the appropriate TB-related diagnosis code.

Irrigation of Venous Access Pump

CPT code 96523 may be billed as a stand-alone procedure. However, if billed on the same day as an office visit, you must use modifier 25 to report a separately identifiable medical service. If you do not use modifier 25, HRSA will deny the E&M code.

Collagen Implants

HRSA pays for CPT code 51715 and HCPCS code L8603 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency).

Ventilator Management

CPT codes 94656, 94657, 94660, and 94662 for Ventilator Management are not billable with Evaluation and Management (E&M) services. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.

Cochlear Implant Services **[Refer to WAC 388-531-0200(4) (c)]**

Cochlear implantation (CPT code 69930) and payment for replacement parts for cochlear implants (HCPCS codes L8615-L8618 and L8621-L8624) given directly to clients requires EPA (see section I). Procedure code L8619 needs PA. If the client does not meet the EPA criteria, then the request requires PA.

When reimbursing for battery packs, HRSA covers the **least costly, equally effective** product.

> **Note:** HRSA does not pay providers for repairs or replacements that are covered under the manufacturer's warranty.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 61886, and 64573) requires prior authorization (refer to Section I - Prior Authorization).
- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.
- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.
- HRSA does not pay for VNS and related procedures for a diagnosis of Depression (CPT 64550-64565, 64590-64595, 95970, 95974, and 95975).

Apheresis (CPT codes 36511-36516)

HRSA does not allow Apheresis in combination with any E&M services. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.

Osseointegrated Implants

- Insertion of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.
- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Outpatient Cardiac Rehabilitation

Eligible programs:

- CNP;
- Children's Health;
- LCP-MNP (only clients 20 years of age and younger);
- GAU; and
- GAU-ADATSA.

HRSA covers outpatient cardiac rehabilitation in a hospital outpatient department for eligible clients who:

- Are referred by a physician;
- Have coronary artery disease (CAD);
- Do not have specific contraindications to exercise training; and
- Have:
  - ✓ A recent documented history of acute myocardial infarction (MI) within the preceding 12 months;
  - ✓ Had coronary angioplasty (coronary artery bypass grafting [CABG];
  - ✓ Percutaneous transluminal coronary angioplasty [PTCA]); and/or
  - ✓ Stable angina.

You must bill physician services with procedure code 93798 that includes continuous ECG monitoring (per session) with one of the following diagnosis codes:

- 410.0-410.9 (Acute myocardial infarction);
- 413.0-413.9 (Angina pectoris);
- V45.81 (Aortocoronary bypass status);
- V45.82 (Percutaneous transluminal coronary angioplasty status); or

> **Note:** Cardiac rehabilitation does not require PA, and it is only approved for the above diagnoses.

HRSA **does not** cover procedure code 93797.

The outpatient cardiac rehab program hospital facility must have:

- A physician on the premise at all times, and each client is under a physician's care;
- Cardiopulmonary emergency equipment and therapeutic life-saving equipment available for immediate use;
- An area set aside for the program's exclusive use while it is in session;
- Personnel who are:
  - ✓ Trained to conduct the program safely and effectively;
  - ✓ Qualified in both basic and advanced life-support techniques and exercise therapy for coronary disease; and
  - ✓ Under the direct supervision of a physician;
- Non-physician personnel that are employees of the hospital;
- Stress testing:
  - ✓ To evaluate a patient's suitability to participate in the program;
  - ✓ To evaluate chest pain;
  - ✓ To develop exercise prescriptions; and
  - ✓ For pre and postoperative evaluation of coronary artery bypass clients;
- Psychological testing or counseling provided if a client:
  - ✓ Exhibits symptoms such as excessive fear or anxiety associated with cardiac disease; or
  - ✓ Has a diagnosed mental, psychoneurotic, or personality disorder;
- Continuous cardiac monitoring during exercise or ECG rhythm strip used to evaluate a client's exercise prescription.

HRSA covers up to 24 sessions (usually 3 sessions a week for 4-6 weeks) of cardiac rehab exercise sessions (phase II) per event. The clients must have continuous ECG monitoring. HRSA only covers continued participation in cardiac rehab exercise programs beyond 24 sessions on a case-by case basis with preauthorization.

Diabetic Education (HCPCS Code G0108 and G0109)

- HRSA pays for up to 6 hours of diabetic education/diabetic management per client, per calendar year.

- Certified diabetic education providers must be approved by the Department of Health (DOH). Contact the number provided below to receive a list of DOH approved diabetic education providers.

- All physicians, ARNP's, clinics, hospitals, and Federally Qualified Health Centers are eligible to apply to be a diabetes education provider. The Diabetes Control Program (DCP) at DOH develops the application criteria and evaluates all applications for this program.

- A minimum of 30 minutes of education/management must be provided per session.

- Diabetes education may be provided in a group or individual setting, or a combination of both, depending on the client's needs.

Note: HRSA does not reimburse for diabetes education if those services are an expected part of another program provided to the client (e.g. school-based health services or adult day health services).

For more information on becoming a diabetes education provider and to obtain an application, write or call:

Diabetes Prevention and Control Program
Department of Health
PO Box 47855
111 Israel Rd SE
Tumwater, WA 98501
360.236.3617

Note: HRSA is still in the process of writing the Diabetic Education Billing Instructions. Please refer to memo 05-41 until the new billing instructions are published.

Genetic Counseling and Genetic Testing

HRSA covers genetic counseling and genetic testing for pregnant women and postpartum women up to 90 days after delivery and infants up to 90 days after birth. This does not require PA for fee-for-service (FFS) clients or for clients on HRSA managed care plans. To locate the nearest DOH-approved genetic counselor call DOH at 253.395.6742.

HRSA covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E&M code.

Certain genetic testing procedure codes need PA. Physicians- or HRSA-approved genetic counselors must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly.

Out-of-State Hospital Admissions **(does not include border hospitals)**

Emergency Admissions

HRSA covers emergency admissions for clients on an eligible program (GA-U clients are not covered out-of-state except in some border areas).

Elective Admissions

HRSA requires PA for elective admissions for clients on an eligible program (GA-U clients have no out-of-state benefit) and approves them for covered medical services that are medically necessary, and not available in hospitals in the state of Washington or border areas.

When requesting PA, you must send a completed Out-of-State Medical Services Request Form [DSHS 13-787] with additional documentation listed on form to the Medical Request Coordinator (see *Important Contacts* section).